DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. BUILDING _____ B. WING _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAND COUNTY NURSING & REHABILITATION CENTER	12185 GRAPEFIELD ROAD BASTIAN, VA 24314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/11/17 through 04/13/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 57 certified bed facility was 53 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents #1 through #12, #17 and #18) and 4 closed record reviews (Residents #13 through #16).	F 000	Kissito Healthcare shares the state's focus on the health, safety, and well being of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, we have implemented a plant of correction to demonstrate our continuing effort to provide quality care to our residents.	
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records ,	F 164	RN #2 was immediately educated on providing privacy for residents when administering medications via peg tube. Current residents in the center have the potential to be affected. Center staff have been educated by the Director of Nursing/designee on the center's policy for providing privacy for residents when providing care including administering medications via peg tube. The Director of Nursing/designee will via direct observation during morning rounds five times per week to ensure privacy is being provided for residents during care and/or medication administration. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed Richie D. Alba | ADMINISTRATOR | 5/5/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide privacy while providing care and services for 1 of 18 residents in the survey sample during the medication pass and pour observation (Resident #9). The findings included: The facility staff failed to provide privacy to Resident #9 while providing tube feeding care. Resident #9 was readmitted to the facility on 4/5/17 with the following diagnoses of, but not limited to Adult Failure to Thrive, severe protein calorie malnutrition, anxiety disorder, gastrostomy, diabetes and hematuria. The	F 164		

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F 164	Continued From page 2 current 14 day MDS (Minimum Data Set) was in progress at the time of this clinical record review and the surveyor obtained the MDS information for Resident #9 from the previous MDS that was completed on 1/9/17 for a readmission to the facility. Resident #9 was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 2 staff members for bathing. The state and federal surveyors accompanied registered nurse (RN) #2 into Resident #9's room for a medication pass and pours observation on 4/11/17 at 4 pm. During the observation, RN #2 pulled back the bed linens of Resident #9, exposing the resident's tube feeding site to the other resident in the room. RN #2 did not pull the privacy curtain between the two residents in the room or the curtain by the door while providing tube feeding care to Resident #9. On 4/13/17 at 10:15 am, the surveyor met with the director of nursing in her office. The surveyor notified the director of nursing of the above documented findings with Resident #9 that occurred during the medication pass and pour observation. The surveyor asked for a policy regarding resident privacy when staff was providing care to the resident. The director of nursing provided a copy of the policy titled "Giving a Bath or Shower" to the surveyor and stated, "This is what I would hold my staff accountable to even when providing tube feeding care to a resident". The policy stated the following under the section of "Steps in the	F 164		

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F 164	Continued From page 3 Procedure": " ...4. Close the room door and pull the cubicle curtain around the bed for privacy ..." The administrative team was notified of the above documented findings by the surveyor on 4/13/17 at 11:35 am and again at 6:35 pm. No further information was provided to the surveyor prior to the exit conference on 4/13/17.	F 164		
F 170 SS=D	483.10(g)(8)(i)(9)(i)-(iii)(h)(2) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL (g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (g)(9) communications such as email and video communications and for internet research. (i) If the access is available to thefacility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. (h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to	F 170	Resident #10 is receiving her mail unopened. Current residents in the center have the potential to be affected. Facility staff was educated by the Director of Nursing/designee on resident rights to include residents have the right to receive mail unopened. In addition, education also included only if the resident asked for staff to open their mail, staff should leave the unopened mail with the resident. The Director of Nursing/designee will interview five alert and oriented residents weekly to ensure they are receiving their mail unopened. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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F 170	Continued From page 4 send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure mail was delivered unopened for 1 of 18 Residents (Resident #10). The findings include: On 4/12/17 at 10:05am during a group meeting of 5 alert and oriented residents, the question related to mail was asked. All but one of the 5 residents said the mail was opened when they received it. The one who did not say her mail was opened (group resident #1) said, "I haven't been here long enough to get mail." Group resident #2 said, "I am blind so I've asked them to open it and read it to me." Group resident #3 said, "I think it is good for it to be opened; there could be drugs in it." During a follow-up to the group interview concerns, all but one of the residents said the mail was opened in front of them. Group Resident #3 said, "I don't want to get anyone in trouble." Resident #10 insisted her mail was received opened prior to her getting it and not in front of her. She said, "I don't want it opened, and I have been getting it opened. I asked my sister if they were supposed to do it." On 4/13/17 at approximately 8:30am, the activities director was asked who delivered the mail. She stated, "I do and sometimes the administrator does." She was asked if she	F 170		

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F 170	Continued From page 5 opened the mail prior to giving it to them. She said, "Only if they want me to and I open it in front of them." The administrator also followed up with the residents about the opened mail and informed the surveyor that Resident #10 did not want it opened now, but due to her previous poor health needed assistance with opening her mail. He was asked if he opened mail prior to them getting it, he said, "No." On 4/13/17 at 6:40pm during the end of the day meeting, the administration, director of nurses, and the regional nurse were informed of the mail issue. Prior to exit on 4/13/17 at 9:45pm, no further information was provided to the surveyor related to the aforementioned.	F 170		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95,	F 226	New Hire #1was received abuse training on 4/14/17.. New Hire #2 received abuse training on 4/14/17. New Hire #5 OIG is no longer employed at the center. New Hire #20 is a PRN employee –the criminal background ,sworn statement and abuse training will be completed prior to her next scheduled shift. New Hires #4 received abuse training on 4/14/17. New Hire #21 received abuse training on 4/17/17. An audit of new hires for the last 6 months was completed to ensure the required information is in the personnel files and completed timely. The Chief Administrative Officer(CAO)/Director of Nursing(DON) and the Director of Human Resources was educated by the Corporate Human Resources Director on the center's abuse and neglect policy. The education included all the requirements for new hires-criminal background checks, abuse and neglect training, licensure checks. Etc. The items are to be completed before any contact with residents.	5/28/17

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F 226	Continued From page 6 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at §483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, employee file review, and the Code of Virginia, the facility staff failed to follow their policy and procedure in regards to new employee hires for 5 of 25 new hires/rehires to include a contract employee and failed to ensure employees were inserviced on abuse and/or neglect prior to working on the floor and having direct contact with the Residents of thefacility. The findings included. The surveyor reviewed 25 employee files on 04/12/17. Of these 25 employee files 5 did not include any evidence of training on abuse and neglect, 3 did not have their license's verified prior to hire, 1 employee file included an OIG (office of inspector general) background check with no information to indicate when the information was received by the facility, 1 contract	F 226	The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 226	Continued From page 7 employee (respiratory therapist) and a CNA (certified nursing assistant) did not have their criminal background check completed prior to hire, and the contract employee's file did not include any reference checks or a sworn statement. Per the request of the survey team the facility provided a copy of their policy and procedure on abuse. This policy and procedure read in part. Specific procedure/requirements-The organization will screen potential employees for a history of abuse, neglect or mistreating residents. If employment references cannot be obtained, personal references may be obtained. Multi-State registry check and license verifications(s) will be checked from every state registry. State licensure and certification agencies, and applicable registries, will be contacted, PRIOR to hire, to validate current licensure or certification requirements and to determine if the potential employee is in good standing with the registry. Training-At a minimum, education on abuse, neglect, and exploitation will be provided to facility staff upon hire and annually. Reference: State Code of Virginia. "32.1-126.01. Employment for compensation of persons convicted of certain offenses prohibited; criminal record checks required; suspension or revocation of license. Any person desiring to work at a licensed nursing home shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges...A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance	F 226		

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F 226	Continued From page 8 with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange." A review of the facility contract regarding contract employees was reviewed and read in part "...Facility will provide paid "New Employee Orientation" and annual mandatory facility in-service education to_____(company name) therapists, individually or in a group setting as set forth by the VA Department of Health, or other licensing or accrediting body..." New hire #1 had a hire date of 07/25/16 and was employed at the facility as an RN (registered nurse).The facility did not verify this employees license until 01/06/17. The employee file did not include any evidence of abuse training. New hire #2 had a hire date of 10/31/16 and was employed at the facility as a CNA (certified nursing assistant). The facility did not complete the criminal background check until 02/09/17 and the license was not verified until 01/23/17. The employee file did not include any evidence of abuse training. New hire #5 had a hire date of 10/26/16 and was employed as an RN. The OIG background check completed on this employee did not include any information to indicate when it had been received by the facility. New hire #20 had a hire date of 11/30/16 and was employed at the facility as a contract employee in the respiratory therapy department. The facility did not verify this employees license until the survey team asked for verification on 04/12/17.	F 226		

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F 226	Continued From page 9 The facility did not complete a criminal background check through the Virginia State Police; the employee file did not include any reference checks, a sworn statement, or any evidence of abuse training. New hires #4 and #21 employee files did not include any evidence of abuse training. On 04/12/17 at approximately 2:15 p.m. the surveyor interviewed the corporate HR (human resource) personnel. During this interview the HR personnel verbalized to the survey team that they did not have currently have an HR person at the facility and that when they were checking files they had found some employee files where the licenses had not been verified. On 04/13/17 at approximately 11:45 a.m. the administrative team of the facility was notified of the missing information in the employee files. The corporate nurse verbalized to the survey team that before the employees next scheduled shift they would have their abuse training. On 04/13/17 at approximately 2:55 p.m. the surveyor interviewed new hire #1. New hire #1 was asked if she had any abuse and/or neglect training when she had been hired at the facility. New hire #1 verbalized to the surveyor that during orientation she was "pretty sure" she had some but wasn't 100% positive. New hire #1 then added she had watched some videos and there may have been one onabuse. During the abuse and neglect interviews completed by the surveyors at the facility no problems were identified.	F 226		

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F 226	Continued From page 10 No further information regarding these issues was provided to the survey team prior to the exit conference.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to announce themselves prior to entering the resident's room for 2 of 18 residents in the survey sample (Resident #6 and #9). The findings included: 1. The facility staff failed to knock on the door prior to entering during a medication pass and pour observation for Resident #6. Resident #6 was readmitted to the facility on 12/29/16 with the following diagnoses of, but not limited to anemia, high blood pressure, neurogenic bladder, urinary tract infection, anxiety disorder, depression, respiratory failure, dependence on ventilator assistance, tracheostomy, chronic pain and gastrostomy. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/17, coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a	F 241	RN #2 was immediately educated on the center's policy for announcing themselves by knocking on the resident's door prior to entering. Current residents in the center have the potential to be affected. Center staff have been educated by the Director of Nursing/designee on resident rights including the center's policy for announcing themselves prior to entering a resident's room. The Director of Nursing/designee will via direct observation during round observe staff entering resident's room to ensure they are announcing themselves prior to entering room. IN addition, five alert and oriented residents will be interviewed weekly to ensure staff are knocking prior to entering their rooms. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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F 241	Continued From page 11	F 241		

possible score of 15. Resident #6 was also coded as requiring extensive assistance of 2 or more staff members for dressing and being totally dependent 2 or more staff member for bathing.

During the medication pass and pour observation on 4/11/17 at 4 pm, registered nurse (RN) #2 entered the resident's room without knocking on the door before entering. The surveyor knocked on the resident's door prior to entering the room with RN #2.

The director of nursing was notified of the above documented findings on 4/13/17 at 10:15 am in her office. The surveyor requested a copy of the facility's policy on staff knocking on resident's door before entering when delivering care to that resident. The director of nursing stated to the surveyor that she would expect her staff to knock on the resident's door before entering.

At 11:30 am, the surveyor was given a copy ofthe policy titled "Giving a Bath or Shower" and the director of nursing stated "This is what I would expect my staff to do before entering a resident 's room for any reason." Under the section of "Steps in the Procedure", the policy stated the following:

" ...3. Proceed to the resident's room. KNOCK before entering the room ..."

The administrative team was notified of the above documented findings on 4/13/17 at 11:35 am and again at 6:35 pm in the conference room by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 4/13/17.

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F 241	Continued From page 12 2. The facility staff failed to knock on the door of Resident #9's room before entering the room to provide tube feeding care to the resident. Resident #9 was readmitted to the facility on 4/5/17 with the following diagnoses of, but not limited to Adult Failure to Thrive, severe protein calorie malnutrition, anxiety disorder, gastrostomy, diabetes and hematuria. The current 14 day MDS (Minimum Data Set) was in progress at the time of this clinical record review and the surveyor obtained the MDS information for Resident #9 from the previous MDS that was completed on 1/9/17 for a readmission to the facility. Resident #9 was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 2 staff members for bathing. The state and federal surveyors accompanied registered nurse (RN) #2 into Resident #9's room for a medication pass and pours observation on 4/11/17 at 4 pm. RN #2 did not knock on the door of Resident #9 before entering the room to provide tube feeding care to the resident. The state surveyor did knock on the resident's door prior to entering in the room with RN #2. The director of nursing was notified of the above documented findings on 4/13/17 at 10:15 am in her office. The surveyor requested a copy of the facility's policy on staff knocking on resident's door before entering when delivering care to that resident. The director of nursing stated to the surveyor that she would expect her staff to knock on the resident's door before entering.	F 241		

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	495191	A. BUILDING _____ B. WING _____	04/13/2017

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F 241	Continued From page 13 At 11:30 am, the surveyor was given a copy ofthe policy titled "Giving a Bath or Shower" and the director of nursing stated "This is what I would expect my staff to do before entering a resident 's room for any reason." Under the section of "Steps in the Procedure", the policy stated the following: " ...3. Proceed to the resident's room. KNOCK before entering the room ..." The administrative team was notified of the above documented findings by the surveyor on 4/13/17 at 11:35 am and again at 6:35 pm. No further information was provided to the surveyor prior to the exit conference on 4/13/17.	F 241		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental	F 279	Resident #8 care planned was updated to include pain management with non-pharmacological intervention listed on the care plan. Care plans for current residents in the center with pain management have been reviewed to ensure pain management has been addressed including non-pharmacological interventions. The Director of Nursing/designee will educated the interdisciplinary team on writing and updating care plan s to reflect the resident's current physical and psychological functioning. The Director of Nursing/designee will review three care plans weekly to ensure the care plan is complete and accurate and pain care plans are in place with non pharmacological in place. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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F 279	Continued From page 14 and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 279		

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F 279	Continued From page 15 section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to implement a comprehensive care plan for 1 of 18 residents in the survey sample (Resident #8). The findings included: The facility staff failed to implement a comprehensive care plan for pain for Resident #8. Resident #8 was admitted to the facility on 2/8/17 with the following diagnoses of, but not limited to anemia, Coronary Artery Disease, heart failure, high blood pressure, End-Stage Renal Disease, Pneumonia, Diabetes, high potassium, high cholesterol, depression and respiratory failure. The MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/17 scored the resident as having a BIMS (Brief Mental Status) score of 14 out of a possible score of 15. Resident #8 was also coded as requiring extensive assistance of 2 staff members for personal hygiene and dressing. The resident was coded as being totally dependent on 2 or more staff members for bathing. During the clinical record review on 4/11/17, the surveyor noted that the pain medication, Lortab, was given to the resident on the following dates and times: 4/5/17 at 8 am, 4/8/17 at 8 am, 4/11/17 at 9 am and 4/12/17 at 8 am. On the resident's MAR (Medication Administration Record) for the above dates the pain assessment q (every) shift rated the resident as a "0" which represents "no pain" on the pain scale. The	F 279		

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F 279	Continued From page 16	F 279		

physician had ordered the pain medication," Lortab 7.5-325 mg (milligram) Give 1 tablet by mouth every 8 hours as needed for pain". There were no non-pharmacological interventions documented in the nurses' notes prior to the administration of the pain medication, Lortab for the above documented dates and times.

The comprehensive care plan was also reviewed by the surveyor on 4/11/17. The comprehensive care plan did not include any documentation for pain or interventions to be used for the resident when pain was experienced.

On 4/12/17 at 3pm, the surveyor notified the director of nursing of the above documented findings. The director of nursing stated "There are no non pharmacological interventions documented on the pain medicines and it wasn't care planned either." The surveyor requested a copy of the facility's policy on pain management from the director of nursing.

The administrative team was notified of the above documented findings on 4/12/17 at approximately 5 pm by the surveyor.
The surveyor received a copy of the facility's policy titled "Pain Management" from the director of nursing on 4/13/17 at 11:35 am. The policy stated the following under Procedures:

"1. All new admissions will be assessed for the risk and presence of pain on admission.

2. Residents will be reassessed quarterly and as indicated.

3. The interdisciplinary team will provide pain management interventions. Pain management includes, but is not limited to:

a. Involving resident in pain management plan

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F 279	Continued From page 17 b. assessing pain and evaluating response to pain management scale based on patient self-report. c. educating staff, patients and families regarding pain management approaches. d. Use of both medications and non-drug interventions of the analgesia ... 5. ...This data will be documented in the medical record in the nurses' notes, the physician's progress notes and reflected and modified in resident's care plan as appropriate ..." The administrative team was again notified of the above documented findings on 4/13/17 at 6:35 pm. No further findings were provided to the surveyor prior to the exit conference on 4/13/17.	F 279		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and the Code of Virginia, the facility staff failed to follow professional standards of nursing practice for 4 of 18 Residents, Residents #4, #6, #8, and #9. The findings included.	F 281	Resident #4 is receiving Synthroid medication as ordered. Resident #6 has a physician order for peg tube flushes. Resident #8 has a Nepro order which includes the amount. RN #2 was immediately educated on the proper method for checking for placement of a peg tube. Current residents in the center have the potential to be affected. Licensed Nurses in the center will be educated by the Director of Nursing/designee on the 5 R(s) of medication administration. Education will also include the proper method of check peg tube placement. In addition, licensed nurses will also be educated on the proper procedure when medications are not available for administration. The Director of Nursing/designee will be notified when medications are not available for administration. In addition a list of medications in the STAT box will be placed in the front of each medication administration record for reference. The Director of Nursing/designee will observe two nurses weekly to ensure the 5 R(s) of medication administration are being adhered to. In addition, at least one of these observations will include the proper placement of a peg tube.	5/28/17

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F 281	Continued From page 18 1. For Resident #4, the facility staff borrowed the medication synthroid from another Resident. This medication was available in the stat box at the facility. The record review revealed that Resident #4 had been admitted to the facility 04/03/13. Diagnoses included, but were not limited to, hypothyroidism, diabetes, major depressive disorder, dementia, peripheral vascular disease, anorexia, and hypertension. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/13/17 was coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. The clinical record included a physicians order dated 04/07/17 to increase the Residents synthroid (thyroid medication) from 175 mcg to 200 mcg everyday. A review of the Residents MAR (medication administration record) revealed that on 04/08/17 LPN (licensed practical nurse) #2 documented on the Residents MAR that they had borrowed this medication from another Resident of the facility. A review of the stat box list provided to the surveyor indicated that this medication would have been available in the stat box for administration. A copy of what the facility used as their standard of practice regarding borrowing of medication was requested from the DON (director of nursing). On	F 281	The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 281	Continued From page 19 04/12/17 at approximately 8:30 a.m. the DON provided the surveyor with a copy of their policy and procedure titled "LTC (long term care) Facility's Pharmacy Services and Procedures Manual." The DON verbalized to the surveyor that this policy and procedure was their standard of practice and she had nothing specific regarding borrowing of medications. This policy and procedure read in part "Upon discovery that the Facility has an inadequate supply of a medication to administer to a resident. Facility staff should immediately initiate action to obtain the medication from the Pharmacy...If the next available delivery causes delay or a missed dose in the resident's medication schedule, the Facility nurse should obtain the medication from the emergency stock supply to administer the dose..." Per the Code of Virginia-18VAC110-20-530. Pharmacy's responsibilities to long-term care facilities. "The pharmacy serving a long-term care facility shall...Ensure that personnel administering the drugs are trained in using the dispensing system provided by the pharmacy...Ensure...that the medication of one patient shall not be transferred to another patient..." On 04/13/17 at approximately 11:45 a.m., during a meeting with the survey team, the DON verbalized to the survey team that the nurse should have checked the stat box for the medication and if it had not been available should have contacted the pharmacy for a stat run. No further information regarding the borrowing of this medication was provided to the survey team prior to the exit conference.	F 281		

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F 281	Continued From page 20 2. For Resident #6, the facility staff failed to routinely flush the Residents peg tube. A percutaneous endoscopic gastrostomy (PEG) is a safe and effective way to provide food, liquids and medications (when appropriate) directly into the stomach. The procedure is done for patients who are having trouble swallowing. https://my.clevelandclinic.org/health/articles/percutaneous-endoscopic-gastrostomy-peg The record review revealed that Resident #6 had been admitted to the facility 07/07/16. Diagnoses included, but were not limited to, chronic respiratory failure, muscular dystrophy, hypertension, anxiety disorder, and major depressive disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/14/17 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Resident #6 had a peg tube that was not currently being used for nutritional intake. The Resident's current order summary report included the order "May give meds po (by mouth) or via peg." This order summary report did not include any orders for flushing the tube. The Residents comprehensive care plan included the focus area history of need for feeding tube related to inadequate oral intake with a diagnosis of malnutrition. Peg present but not used for intake. Interventions for flushes regarding this	F 281		

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F 281	Continued From page 21 peg tube had been canceled. On 04/12/17 at approximately 12:30 p.m. RN (registered nurse) #1 was interviewed regarding the Residents peg tube. RN #1 verbalized to the surveyor that the Residents peg tube was not routinely flushed. On 04/12/17 at approximately 12:45 p.m. the DON (director of nursing) was interviewed regarding the flushing of the Residents peg tube. The DON verbalized to the surveyor that the peg tube was not routinely flushed but it was flushed prior to use (if used) to check for patency. The surveyor requested the facility's standard of practice regarding peg tubes from the DON. The DON provided the surveyor with a copy of their policy and procedure titled "Enteral Feeding Guidelines" This policy and procedure did not include any documentation in regards to flushes when the peg tube was not being used for nutritional purposes. Page 170 of this policy and procedure read in part "Miscellaneous...All feeding tubes must be irrigated...Before and after administration of medication...Before and after bolus feedings..." The DON also provided the surveyor with a copy of their standard of practice regarding peg tubes/feeding tubes from a book titled "NURSE'S POCKET COMPANION" with a date of 1994. Under the heading of "Feeding tube insertion and removal" page 292 "Special considerations Flush the feeding tube every 8 hours with up to 60 ml of 0.9% sodium chloride solution or water to maintain patency..." According to the national institute of health "The	F 281		

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F 281	Continued From page 22 tube should be flushed before and after each feed and administration of medicine to prevent clogging of the tube and subsequent blockage. This blockage occurs particularly in small-bore feeding tubes secondary to feeding with thick formulas, inadequately crushed medications or incompatibility between medications and enteral feeds. In addition to regular flushing of the tube, dissolving medications in water before administration..." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4069302/ Prior to the exit conference the facility staff provided the surveyor with a copy of a physician order dated 04/12/17 at 20:01 (8:01 p.m.) "Free water flushes at 60 ml Q (every)-Shift via PEG every shift for PEG patency." No further information regarding this issue was provided to the survey team prior to the exit conference. 3. The facility staff failed to document the dosage of the medication, Nepro when administrated to Resident #8. Resident #8 was admitted to the facility on 2/8/17 with the following diagnoses of, but not limited to anemia, Coronary Artery Disease, heart failure, high blood pressure, End-Stage Renal Disease, Pneumonia, Diabetes, high potassium, high cholesterol, depression and respiratory failure. The MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/17 scored the resident as having a BIMS (Brief Mental Status) score of 14 out of a possible score of 15. Resident #8 was also coded as requiring extensive assistance of 2 staff members for personal hygiene and dressing. The resident was	F 281		

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F 281	Continued From page 23 coded as being totally dependent on 2 or more staff members for bathing. During the clinical record review on 4/11/17, the surveyor noted a physician order dated for 2/27/17 for the medication Nepro which stated the following: "Nepro tid (three times a day) po (by mouth)." On 4/11/17 at 3:30 pm, LPN (Licensed Practical Nurse) #1 came into the conference room and the surveyor asked LPN #1 to review the MAR (Medication Administration Record) for Resident #8 concerning the above documented physician's order. LPN #1 stated "There should be an amount there to give her. There isn't a dosage." The surveyor asked LPN #1 to provide the surveyor a copy of the facility's policy or professional standard that holds staff accountable for administration of medications to the residents. A copy of the facility's policy was given to the surveyor titled "6.0 General Dose Preparation and Medication Administration" which stated under section 3 "Prior to the Medication Administration" that stated: " ...3.1 Facility should verify each time a medication is administrated that it is the correct drug, at the correct dose, the correct route, at the correct rate, at the correct time, for the correct resident ..." The administrative team was notified of the above documented findings on 4/12/17 at approximately 5 pm and again on 4/13/17 at 11:35 am by the surveyor in the conference room. No further information was provided to the surveyor prior to the exit conference on 4/13/17.	F 281		

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F 281	Continued From page 24 4. The facility staff failed to follow professional nursing standards when flushing a feeding tube for Resident #9. Resident #9 was readmitted to the facility on 4/5/17 with the following diagnoses of, but not limited to Adult Failure to Thrive, severe protein calorie malnutrition, anxiety disorder, gastrostomy, diabetes and hematuria. The current 14 day MDS (Minimum Data Set) was in progress at the time of this clinical record review and the surveyor obtained the MDS information for Resident #9 from the previous MDS that was completed on 1/9/17 for a readmission to the facility. Resident #9 was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 2 staff members for bathing. The state and federal surveyors accompanied registered nurse (RN) #2 into Resident #9's room for a medication pass and pours observation on 4/11/17 at 4 pm. RN #2 changed the feeding tubing for Resident #9. RN#2 put 30 ml (milliliters) of water into a syringe and pushed it through the feeding tube using the plunger. The state surveyor asked the director of nursing for a copy of the facility's standard of nursing practice regarding the care and administration of medications through a feeding tube on 4/13/17 at 10:15 am. The director of nursing gave the surveyor a copy of the facility's policy titled "Enteral Feeding Guidelines" which she stated the facility would use as their standard of nursing practice for feeding tubes. Under the section of	F 281		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 25 "Key Procedural Points", the policy stated the following: " ...1. Assessment: Prior to the administering medication, water or nutrients check tube placement listen while inserting 15 cc of air and withdrawing gastric content ... 2. Patency: Flush with 15 cc of water before and after medications and/or feeding ..." The administrative team was notified of the above findings by the surveyor on 4/13/17 at 11:35 am and again at 6:15 pm. No further information was provided to the surveyor prior to the exit conference on 4/13/17.	F 281		
F 285 SS=E	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment , care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a	F 285	PASARR(s) for residents #8, 4, 6, 1, 2, 10, and 11 were completed on 4/13/17. An audit of current residents in the center was conducted to ensure PASARR(s) were completed on admission. Social Services Director/Admission staff will be educated by the Corporate Director of Clinical Reimbursement/designee on the requirements for completing the PASSARR. The Director of Nursing/designee will audit new admissions records to ensure the PASSAAR has been completed on admission. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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	495191	A. BUILDING _____ B. WING _____	04/13/2017

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F 285	Continued From page 26 mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section-	F 285		

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F 285	Continued From page 27 (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state	F 285		

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F 285	Continued From page 28	F 285		

mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to complete a Pre-Admission Screening and Resident Review for 7 of 18 residents in the survey sample (Resident #'s 8, 4, 6, 1, 2, 10, and 11).

The findings included:

1.The facility staff failed to complete a Pre-Admission Screening and Resident Review for Resident #8.

Resident #8 was admitted to the facility on 2/8/17 with the following diagnoses of, but not limited to anemia, Coronary Artery Disease, heart failure, high blood pressure, End-Stage Renal Disease, Pneumonia, Diabetes, high potassium, high cholesterol, depression and respiratory failure. The MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/17 scored the resident as having a BIMS (Brief Mental Status) score of 14 out of a possible score of 15. Resident #8 was also coded as requiring extensive assistance of 2 staff members for personal hygiene and dressing. The resident was coded as being totally dependent on 2 or more staff members for bathing.

During the clinical record review on 4/11/17, the surveyor noted that a Pre-admission Screening and Resident Review (PASRR) had not been completed within 30 days to the resident being

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F 285	Continued From page 29 admitted to the nursing facility. Resident #8 had been admitted to the facility on 2/8/17. In the end of the day meeting on 4/12/17 at approximately 5:00 pm, the administrative team was notified of the above documented findings. The administrator stated he would have someone to look into this and provide the surveyor with the information needed. On 4/13/17 at approximately 2 pm, the surveyor was provided a copy of a PASRR dated for 4/13/17 for Resident #8. The administrative team was again notified of the above findings on 4/13/17 at 6:50 pm by the surveyor. No further information was provided to the surveyor prior to the exit conference on 4/13/17. 2. For Resident #4, the facility staff failed to complete a PASRR (pre-admission screening and resident review) prior to the Resident being admitted to the facility. The 802 (roster/sample matrix) provided to the surveyors by the facility identified this Resident as having a mental illness. The record review revealed that Resident #4 had been admitted to the facility 04/03/13. Diagnoses included, but were not limited to, diabetes, major depressive disorder, dementia, peripheral vascular disease, anorexia, and hypertension. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/13/17 was coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making.	F 285		

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F 285	Continued From page 30 Section I (active diagnoses) included the diagnoses of non-Alzheimer's dementia, anxiety disorder, depression, and psychotic disorder. During the record review the surveyor was unable to locate a PASRR for this Resident. On 04/13/17 at approximately 11:45 a.m., during a meeting with the survey team, the administrative staff was notified that Resident #4's clinical record did not include a PASRR. On 04/13/17 the SW (social worker) provided the surveyor with a copy of a PASRR that she had completed that day. The facility provided the survey team with a copy of their policy/procedure titled "Abuse" This document read in part "...Potential residents will be screened during the pre-admission process to determine if the facility can meet their needs and to determine if the resident requires any special MI/MR services." On 04/13/17 at approximately 6:00 p.m. the corporate director of MDS provided the survey team with a copy of a document titled "VIRGINIA PASRR AN INTRODUCTION TO VIRGINIA'S PREADMISSION SCREENING AND RESIDENT REVIEW PROCESS." Page 3 of this document read in part "PASRR requires that anyone admitted to a Medicaid funded NF (nursing facility) be screened to identify the presence of serious mental illness, intellectual disability...If a qualifying condition is known or suspected, an individualized evaluation must be conducted to ensure that the nursing facility is the most appropriate place for the person to live and receive needed services..."	F 285		

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F 285	Continued From page 31 On 04/13/17 at approximately 6:35 p.m. the surveyors meet with the administrative team of the facility. During this meeting the administrative team was made aware that Resident #4 did not have a PASRR completed prior to being admitted to the facility and that the SW had provided the surveyor with a copy of a PASRR that had been completed by her today. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #6, the facility staff failed to complete a PASRR (pre-admission screening and resident review) prior to the Resident being admitted to the facility. The 802 (roster/sample matrix) provided to the surveyors by the facility identified this Resident as having a mental illness. The record review revealed that Resident #6 had been admitted to the facility 07/07/16. Diagnoses included, but were not limited to, chronic respiratory failure, muscular dystrophy, hypertension, anxiety disorder, and major depressive disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/14/17 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section I (active diagnoses) included the diagnoses anxiety disorder and depression. During the record review the surveyor was unable to locate a PASRR for this Resident.	F 285		

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F 285	Continued From page 32 On 04/13/17 at approximately 11:45 a.m., during a meeting with the survey team, the administrative staff was notified that Resident #6's clinical record did not include a PASRR. On 04/13/17 the SW (social worker) provided the surveyor with a copy of a PASRR that had been completed by her that day. The facility provided the survey team with a copy of their policy/procedure titled "Abuse" This document read in part "...Potential residents will be screened during the pre-admission process to determine if the facility can meet their needs and to determine if the resident requires any special MI/MR services." On 04/13/17 at approximately 6:00 p.m. the corporate director of MDS provided the survey team with a copy of a document titled "VIRGINIA PASRR AN INTRODUCTION TO VIRGINIA'S PREADMISSION SCREENING AND RESIDENT REVIEW PROCESS." Page 3 of this document read in part "PASRR requires that anyone admitted to a Medicaid funded NF (nursing facility) be screened to identify the presence of serious mental illness, intellectual disability...If a qualifying condition is known or suspected, an individualized evaluation must be conducted to ensure that the nursing facility is the most appropriate place for the person to live and receive needed services..." On 04/13/17 at approximately 6:35 p.m. the surveyors meet with the administrative team of the facility. During this meeting the administrative team was made aware that Resident #6 did not have a PASRR completed prior to being admitted	F 285		

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F 285	Continued From page 33 to the facility and that the SW had provided the surveyor with a copy of a PASRR that had she had completed today. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. The facility staff failed to complete a preadmission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #1. The Code of Virginia reads "§ 32.1-330. Preadmission screening required. All individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility services as defined in that plan. The Department shall require a preadmission screening of all individuals who, at the time of application for admission to a certified nursing facility as defined in § 32.1-123 http://law.lis.virginia.gov/vacode/32.1-123/>, are eligible for medical assistance or will become eligible within six months following admission. For community-based screening, the screening team shall consist of a nurse, social worker or other assessor designated by the Department, and physician who are employees of the Department of Health or the local department of social services or a team of licensed physicians, nurses, and social workers at the Wilson Workforce and Rehabilitation Center (WWRC) for WWRC clients only. For institutional screening, the Department shall contract with acute care hospitals. The Department shall contract with other public or private entities to conduct required community-based and institutional screenings in	F 285		

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F 285	Continued From page 34 addition to or in lieu of the screening teams described in this section in jurisdictions in which the screening team has been unable to complete screenings of individuals within 30 days of such individuals' application." The surveyor reviewed Resident #1's clinical record on 4/11/17 and on 4/12/17. Resident #1 was admitted to the facility on 4/1/ 16 with diagnoses that included, but were not limited to: chronic obstruction pulmonary disease, diabetes mellitus, anxiety, hypertension, bipolar, urinary tract infection, Alzheimer's disease, and stroke. Resident #2's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/22/17 assessed the cognitive status as 4 out of 15 in Section C Summary Score. During the clinical record review, the surveyor was unable to locate the pre-admission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #1. The surveyor interviewed the social worker on 4/13/17 at 5:30pm and asked the social worker to locate the pre-admission screening form. The social worker stated that Resident #1 didn't have one. The social worker stated the pre-admission screening was done at the hospital normally, but she did not receive a copy from all the hospitals. At approximately 6:00pm, the social worker provided a copy of a Level 1 screen dated 4/13/17, that she had signed. The surveyor informed the administrator, the director of nurses, and the assistant director of nurses of the above findings on 4/13/16 at	F 285		

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F 285	Continued From page 35 6:40pm. No further information was provided prior to the exit conference on 4/13/17. 5. The facility staff failed to complete a preadmission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #2. The surveyor reviewed Resident #2's clinical record on 4/11/17 and 4/12/17. Resident #2 was admitted to the facility on 3/30/16, and readmitted on 1/14/17, with diagnoses that included, but were not limited to: chronic obstruction pulmonary disease, diabetes mellitus, anxiety, depression, pulmonary hypertension, bipolar, urinary retention, hypothyroidism, atrial fibrillation, insomnia, and dependence on respirator. Resident #2's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/22/17, assessed the cognitive status as 15 out of 15 in Section C Summary Score. During the clinical record review, the surveyor was unable to locate the pre-admission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #2. The surveyor interviewed the social worker on 4/13/17 at 5:30pm and asked the social worker to locate the pre-admission screening form. The social worker stated that Resident #2 didn't have one. The social worker stated the pre-admission screening was done at the hospital normally, but she did not receive a copy from all the hospitals. At approximately 6:00pm, the social worker	F 285		

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F 285	Continued From page 36 provided a copy of a Level 1 screen for Resident #2 dated 4/13/17, that she had signed. The surveyor informed the administrator, the director of nurses, and the assistant director of nurses of the above findings on 4/13/16 at 6:40pm. No further information was provided prior to the exit conference on 4/13/17. 6. The facility staff failed to complete a preadmission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #10. The surveyor reviewed Resident #10's clinical record on 4/13/17. Resident #10 was admitted to the facility on 4/5/16 and readmitted on 2/11/17, with diagnoses that included, but were not limited to: chronic obstruction pulmonary disease, acute and chronic respiratory failure, insomnia, depression, and tracheostomy. Resident #10's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/06/17, assessed the cognitive status as 15 out of 15 in Section C Summary Score. During the clinical record review, the surveyor was unable to locate the pre-admission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #10. The surveyor interviewed the social worker on 4/13/17 at 5:30pm and asked the social worker to locate the pre-admission screening form. The social worker stated that Resident #10 didn't have one. The social worker stated the pre-admission	F 285		

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F 285	Continued From page 37 screening was done at the hospital normally, but she did not receive a copy from all the hospitals. At approximately 6:00pm, the social worker provided a copy of a Level 1 screen for Resident #10 dated 4/13/17, that she had signed. The surveyor informed the administrator, the director of nurses, and the assistant director of nurses of the above findings on 4/13/16 at 6:40pm. No further information was provided prior to the exit conference on 4/13/17. 7. The facility staff failed to complete a preadmission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident #11. The surveyor reviewed Resident #11's clinical record on 4/13/17. Resident #11 was admitted to the facility on 5/1/13, and readmitted on 4/7/17, with diagnoses that included, but were not limited to: stroke, kidney disease, diabetes mellitus, heart failure, and urinary tract infection. Resident #11's was a new admission and did not have a current Minimum Data Set (MDS) assessment completed. However, he could be understood and he could understand verbal communication. During the clinical record review, the surveyor was unable to locate the pre-admission screening for mental illness, mental retardation/intellectual disability, or related condition for Resident # 11. The surveyor interviewed the social worker on	F 285		

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F 285	Continued From page 38 4/13/17 at 5:30pm and asked the social worker to locate the pre-admission screening form. The social worker stated that Resident #11 didn't have one. The social worker stated the pre-admission screening was done at the hospital normally, but she did not receive a copy from all the hospitals. At approximately 6:00pm, the social worker provided a copy of a Level 1 screen for Resident #11 dated 4/13/17, that she had signed. The surveyor informed the administrator, the director of nurses, and the assistant director of nurses of the above findings on 4/13/16 at 6:40pm. No further information was provided prior to the exit conference on 4/13/17.	F 285		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 309	No action taken for resident #5 due to timeframe had already passed. No action was taken for Resident #8 due to timeframe had already passed. Resident #4 physician was notified on 4/13/17 of resident not getting his sliding scale insulin on 3/11 and 3/27/17. No new orders. No action taken for Resident #6 due to the timeframe had already passed. No action taken for Resident #2 due to the timeframe had already passed. No action taken for Resident #10 due to the timeframe had already passed. An audit of resident's BM records was completed to ensure each resident has a BM documented every 3 days and if not the bowel protocol was implemented. An audit of residents receiving sliding scale insulin was conducted to ensure insulin was given as ordered.	5/28/17

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F 309	Continued From page 39 practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences . (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide the necessary care and services to maintain the highest practical well-being for 6 of 18 residents in the survey sample (Resident #'s 5, 8, 4, 6, 2, and 10). The findings included: 1. The facility staff failed to follow the bowel regimen for Resident #5 as prescribed by the physician. Resident #5 was readmitted to the facility on 12/13/13 with the following diagnoses of, but not limited to urinary tract infection, depression, Lupus, chronic pain disorder, morbid obesity and rheumatoid arthritis. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/2/17, the resident was	F 309	Licensed nurses were educated by the Director of Nursing/designee on monitoring resident's bowel movements and to ensure each resident has a BM every three days and if not the bowel protocol has been implemented. In addition nurses were also educated on sliding scale insulin and ensuring insulin is given when the accucheck requires insulin coverage The Director of Nursing/designee will audit 15 bowel records weekly to ensure residents has had a BM every third day and if not the bowel protocol was implemented. In addition the Director of Nursing/designee will audit five medication administration records weekly to ensure insulin has been given as ordered. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 309	Continued From page 40	F 309		

coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 15 out of a possible score of 15. Resident #5 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and totally dependent on 2 or more staff members for bathing.

During the clinical record review on 4/13/17, it was noted by the surveyor that on 3/28/17 to 3/31/17 it was documented that Resident #5 did not have a bowel movement. The resident's MAR (Medication Administration Record) was also reviewed by the surveyor. There was no documentation on the MAR for the month of March, 2017 that the resident received any intervention for no bowel movement on these dates.

The administrative team was notified of the above documented findings on 4/13/17 at 11:35 am by the surveyor.

Registered Nurse (RN) #1 provided the surveyor with a copy of the bowel protocol for Resident #5 at approximately 2 pm. RN #1 stated, "This is the bowel protocol. It doesn't say on here to give or start the bowel protocol if no bowel movement for 3 days but it is understood by staff to start this at that time." On the standing orders that RN #1 provided to the surveyor, under Section 11, Constipation stated the following:

"A. Give 30 cc (milliliters) M.O.M (Milk of Magnesium) po (by mouth) X (times) 1 dose.

B. If no results in 8 hrs. (hours) give Dulcolax 10 mg (milligram) suppository X1.

C. If no results in 8 hrs. give Fleets enema/Soap Suds X1.

D. If no results contact physician for further

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F 309	Continued From page 41 instructions." No further information was provided to the surveyor prior to the exit conference on 4/13/17. 2. The facility staff failed to document non-pharmacological interventions prior to the administration of pain medications to Resident #8. Resident #8 was admitted to the facility on 2/8/17 with the following diagnoses of, but not limited to anemia, Coronary Artery Disease, heart failure, high blood pressure, End-Stage Renal Disease, Pneumonia, Diabetes, high potassium, high cholesterol, depression and respiratory failure. The MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/17 scored the resident as having a BIMS (Brief Mental Status) score of 14 out of a possible score of 15. Resident #8 was also coded as requiring extensive assistance of 2 staff members for personal hygiene and dressing. The resident was coded as being totally dependent on 2 or more staff members for bathing. During the clinical record review on 4/11/17, the surveyor noted that the pain medication, Lortab, was given to the resident on the following dates and times: 4/5/17 at 8 am, 4/8/17 at 8 am, 4/11/17 at 9 am and 4/12/17 at 8 am. On the resident's MAR (Medication Administration Record) for the above dates the pain assessment q (every) shift rated the resident as a "0" which represents "no pain" on the pain scale. The physician had ordered the pain medication," Lortab 7.5-325 mg (milligram) Give 1 tablet by mouth every 8 hours as needed for pain". There were no non-pharmacological interventions	F 309		

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F 309	Continued From page 42 documented in the nurses' notes prior to the administration of the pain medication, Lortab for the above documented dates and times. On 4/12/17 at 3pm, the surveyor notified the director of nursing of the above documented findings. The director of nursing stated "There are no non pharmacological interventions documented on the pain medicines and it wasn't care planned either." The administrative team was notified of the above documented findings on 4/12/17 at approximately 5 pm by the surveyor. The administrative team was again notified of the above documented findings on 4/13/17 at 6:35 pm. No further findings were provided to the surveyor prior to the exit conference on 4/13/17. 3. For Resident #4, the facility staff failed to administer the Residents insulin as ordered by the physician. The Resident should have received 2 units of insulin on 03/11 and 03/27/17. The record review revealed that Resident #4 had been admitted to the facility 04/03/13. Diagnoses included, but were not limited to, diabetes, major depressive disorder, dementia, peripheral vascular disease, anorexia, and hypertension. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/13/17 was coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making.	F 309		

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F 309	Continued From page 43 Section I (active diagnoses) included the active diagnosis of diabetes. The Residents comprehensive care plan included the focus area at risk for hyper/hypoglycemic reactions. Intervention included diabetes medication as ordered by doctor. The Residents clinical record included an order summary sheet signed by the physician on 04/03/17. This order summary sheet included orders to check BS (blood sugar) two times a day and administer humalog sliding scale insulin. For a BS of 150-200 the physician had ordered 2 units of insulin to be administered. A review of the Residents MAR's (medication administration records) for March 2017 revealed that on 03/11/17 at 2100 (9:00 p.m.) the Residents BS was 155-no insulin was given and on 03/27/17 at 2100 the Residents BS was 173 and again no insulin was administered. The administrative staff were notified of the issue regarding the Residents BS during a meeting with the survey team on 04/13/17 at approximately 6:35 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #6, the facility staff failed tofollow their bowel protocol. Resident #6 was identified as not having a BM (bowel movement) on 03/25, 03/26, 03/27, 03/28, and 03/29/17. The record review revealed that Resident #6 had been admitted to the facility 07/07/16. Diagnoses	F 309		

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F 309	Continued From page 44 included, but were not limited to, chronic respiratory failure, muscular dystrophy, hypertension, anxiety disorder, and major depressive disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/14/17 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded 4/3 for toilet use indicating the Resident was totally dependent on 2 staff in this area and 4/2 in the area of personal hygiene indicating the Resident was totally dependent on one person for this task. Section H (bladder and bowel) was coded with a 2 indicating the Resident was frequently incontinent of bowel. The Residents comprehensive care plan included the focus area has a history of ileus approaches included monitor for complications such as diarrhea and gastric distension. Resident #6 was receiving miralax 17 grams one time a day for ileus. A review of the Residents MAR's (medication administration records) indicated this medication had been administered per order. The Resident's clinical record included the following routine standing orders for constipation. "A. Give 20 cc M.O.M. (milk of magnesia) po (by mouth) X 1 dose B. If no results in 8 hrs. Give Dulcolax 10 mg suppository X1 C. If no results in 8 hrs. Give Fleets enema/Soap Suds X1 D. If no results contact physician for further	F 309		

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F 309	Continued From page 45 instructions." A review of the Residents BM's indicated Resident #6 had a BM on 03/24/17 and did not have another BM until 03/30/17. The surveyor was unable to locate any information in the clinical record to indicate the bowel protocol/standing orders had been initiated or followed. The administrative team was notified of the above during a meeting with the surveyors on 04/13/17 at approximately 11:45 a.m. The DON (director of nursing) verbalized to the survey team that the Resident should be monitored every shift for BM's. No further information regarding this issue was provided to the survey team prior to the exit conference. 5. The facility staff failed to follow the bowel protocol for Resident #2. The facility staff failed to follow the physician's standing orders for constipation: "Give 30cc MOM (Milk of Magnesia) PO (by mouth) x 1 dose; if no results in 8 hours give Dulcolax sup (suppository) 10 mg (milligrams) x 1; if no results in 8 hours, give fleets enema/soap suds x1; if no results contact the physician for further instructions." Resident #2's clinical record was reviewed on 4/12/17. Resident #2 was admitted to the facility on 3/30/16 and readmitted on 1/14/17 with diagnoses that included, but were not limited to: heart failure, chronic obstructive pulmonary disease, respiratory failure, urinary retention, diabetes mellitus, atrial fibrillation, and	F 309		

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F 309	Continued From page 46 hypothyroidism. Resident #2's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/17/17, assessed the cognitive status as 15 out of 15 in Section C Summary Score. Resident #2 required extensive assistance of 2 people for transfers and toileting. Resident #2 was coded to be incontinent of bladder and bowel. Resident #2's current Comprehensive Care Plan dated 2/10/17, identified toileting and incontinent of bowel and bladder. The February 2017 Electronic Medication Administration Records (eMARs) were reviewed. The eMARs had no documentation that the physician's standing order for constipation had been followed. The February 2017 Bowel Documentation Form indicated Resident #2 did not have a bowel movement between 2/4/17 through 2/8/17 (5 days), and/or received medications for constipation. LPN #1 was asked to assist in locating information that the bowel protocol had been followed. At 1:11pm, LPN #1 returned and stated, "We don't have the protocol followed," pointing to the bowel document. The surveyor informed the administrative staff of the above finding on 4/12/17 at 5:40pm and requested the facility bowel protocol. Prior to exit on 4/13/17, the facility staff did not provide further information related to the above	F 309		

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F 309	Continued From page 47 issue. 6. The facility staff failed to follow the bowel protocol for Resident #10. The facility staff failed to follow the physician's standing orders for constipation; "Give 30 cc MOM (Milk of Magnesia) PO (by mouth) x 1 dose; if no results in 8 hours give Dulcolax sup (suppository) 10 mg (milligrams) x 1; if no results in 8 hours, give fleets enema/soap suds x1 if no results contact the physician for further instructions." Resident #10's clinical record was reviewed 4/13/17. Resident #10 was admitted to the facility on 4/5/16 and readmitted on 1/1/17 with diagnoses that included, but were not limited to: high blood pressure, pneumonia, insomnia, anxiety, depression, chronic obstructive pulmonary disease, respiratory failure, and tracheotomy status. Resident #10's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/6/17 assessed her cognitive status as 15 out of 15 in Section C for Summary Score. Resident #10 required assistance of 1-2 people for transfers and toileting. Resident #2 was coded to be continent of bladder and bowel. Resident #10's current Comprehensive Care Plan dated 4/6/16 and revision dated 4/13/17, identified she required assistance with activities of daily living due to decreased strength . The February 2017 Electronic Medication Administration Records (eMARs) were reviewed. The eMARs had no documentation that there was	F 309		

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F 309	Continued From page 48 a physician's standing order for constipation. The February 2017 bowel documentation form indicated Resident #10 did not have a bowel movement between 2/12/17 through 2/15/17 (4 days), and/or received medications for constipation. LPN #1 was asked to assist in locating information that the bowel protocol had been followed. On 4/13/17 at 5:25pm, LPN #1 returned and stated, "I could not find where the bowel protocol was followed." The surveyor informed the administrative staff of the above finding on 4/12/17 at 5:40pm and requested the facility bowel protocol. Prior to exit on 4/13/17, the facility staff did not provide further information related to the above issue.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review, the facility staff failed to provide adequate podiatry care for 1 of 18 Residents, Resident #6. The findings included. Resident #6, who was dependent on staff for ADL	F 312	Resident #6 was seen by the podiatrist on 4/25/17. An assessment of current residents in the center was conducted to ensure toe nails were well groomed. Clinical Staff was educated by the Director of Nursing/designee on notification to the Director of Nursing/designee weekly when skin assessments are completed the condition of resident's toenails. If residents are in need to care, their names will be placed on the list to be seem by the podiatrist. The Director of Nursing/designee will observe ten residents weekly to ensure toe nails are well groomed. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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F 312	Continued From page 49 (activities of daily living) care, was observed by the surveyor to have long and thick toenails. The record review revealed that Resident #6 had been admitted to the facility 07/07/16. Diagnoses included, but were not limited to, chronic respiratory failure, muscular dystrophy, hypertension, anxiety disorder, and major depressive disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/14/17 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded 4/2 in the area of personal hygiene indicating the Resident was totally dependent on one person for this task and 2/2 in the area of ROM (range of motion) indicating the Resident had impairments on both sides. The Residents comprehensive care plan included the focus area ADL self-care performance deficit and included the intervention check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. The clinical record included a consult from the podiatrist dated 02/07/17 and read in part "...SUBJECTIVE: this male patient presented for debridement of his nails. OBJECTIVE: Patients nails are mycotic, 1-5 bilaterally (both sides), long and thickened...PLAN: Inspection, evaluation, debridement..." On 04/12/17 at approximately 8:25 a.m. the surveyor observed Resident #6 lying on his bed his legs were stretched out in front of him and	F 312		

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F 312	Continued From page 50	F 312		

were uncovered. The surveyor was able to observe both feet to include his toenails. The Residents toenails were observed by the surveyor to be thick and long.

On 04/12/17 at approximately 12:40 p.m. the surveyor interviewed Resident #6 in his room. The Residents toenails were again observed to be thick and long. The surveyor asked Resident #6 if it bothered him that his toenails were long to which he replied a little.

On 04/13/17 at approximately 11:45 a.m. the surveyors meet with the administrative team of the facility. During this meeting the administrative team was asked about Resident #6's toenails. The DON (director of nursing) verbalized to the survey team that the podiatrist usually left the Residents nails that length due to a history of foot issues.

On 04/13/17 at approximately 4:15 p.m. the surveyor and surveyor #2 entered the Residents room. Resident #6 was observed to be resting on his bed both of his feet were uncovered and were able to be visualized by the surveyors. Resident #6 was asked if he thought his nails were too long to which he replied yes a little. The surveyor then asked when his toenails were cut did they cut them shorter than what they were at the present time to which Resident #6 stated yes.

On 04/14/17 at approximately 11:20 a.m. the surveyor attempted to contact the podiatrist via phone the call went to voicemail and a message was left requesting a return call. The podiatrist retumed the call on 04/14/17 at approximately 1:25 p.m. When asked about Resident #6 the podiatrist verbalized to the surveyor that he did

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	495191	A. BUILOING _____ B. WING _____	04/13/2017

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
BLAND COUNTY NURSING & REHABILITATION CENTER	12185 GRAPEFIELO ROAO BASTIAN, VA 24314

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 51 not remember the Resident but he would be at the facility in 2 weeks and he would take care of the Resident when he was there. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 312		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngealulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to administer the appropriate treatment and/or services in regards to a feeding tube for 1 of 18 residents in the survey sample	F 322	RN #2 was immediately educated on the proper method for checking for placement of a peg tube. Current residents in the center with peg tubes have be potential to be affected. Licensed staff was educated by the Director of Nursing/designee on the proper method for verifying peg tube placement. The Director of Nursing/designee will observe licensed staff weekly to ensure peg tube placement is vertified by using the proper method. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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F 322	Continued From page 52 (Resident #9). The findings included: Resident #9 was readmitted to the facility on 4/5/17 with the following diagnoses of, but not limited to Adult Failure to Thrive, severe protein calorie malnutrition, anxiety disorder, gastrostomy, diabetes and hematuria. The current 14 day MDS (Minimum Data Set) was in progress at the time of this clinical record review and the surveyor obtained the MDS information for Resident #9 from the previous MDS that was completed on 1/9/17 for a readmission to the facility. Resident #9 was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 2 staff members for bathing. The state and federal surveyors accompanied registered nurse (RN) #2 into Resident #9's room for a medication pass and pours observation on 4/11/17 at 4 pm. RN #2 changed the feeding tubing for Resident #9. RN#2 put 30 ml (milliliters) of water into a syringe and pushed it through the feeding tube using the plunger. The state surveyor asked the director of nursing for a copy of the facility's standard of nursing practice regarding the care and administration of medications through a feeding tube on 4/13/17 at 10:15 am. The director of nursing gave the surveyor a copy of the facility's policy titled "Enteral Feeding Guidelines" which she stated the facility would use as their standard of nursing practice for feeding tubes. Under the section of	F 322		

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F 322	Continued From page 53 "Key Procedural Points", the policy stated the following: " ...1. Assessment: Prior to the administering medication, water or nutrients check tube placement listen while inserting 15 cc of air and withdrawing gastric content ... 2. Patency: Flush with 15 cc of water before and after medications and/or feeding ..." The administrative team was notified of the above findings by the surveyor on 4/13/17 at 11:35 am and again at 6:15 pm. No further information was provided to the surveyor prior to the exit conference on 4/13/17.	F 322		
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME (f) Frequency of Meals (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. (f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (f)(3) Suitable, nourishing altemative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent withthe	F 368	No action taken for residents #1, 2, 3, 4, 5, 6 7 or for the residents present at the group meeting due to the timeframe had passed. Current residents in the center have the potential to be affected. Clinical staff was educated by the Director of Nursing/designee regarding offering each resident a snack at bedtime. This task has been added to the CNA electronic documentation. The Director of Nursing/designee will interview five alert and oriented residents weekly to ensure they are being offered snacks at bedtime. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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F 368	Continued From page 54 resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, and staff interview, it was determined the facility staff failed to offer snacks each evening at bedtime . The findings include: On 4/12/17 at 10:05 am, an interview with a group of five of the current facility residents who were alert and oriented was conducted. During the interview the residents were asked if they were offered a bedtime snack. Three of the group said "I don't get offered a snack" and one said "if I ask for one they will bring me one". All agreed they would get one if they asked for it. The other one said they brought her one due to her diet. On 04/13/17 at approximately 7:40 a.m., two surveyors asked multiple residents if they were offered bedtime snacks. The surveyor spoke with unsampled Resident #1 and asked her if she was offered a snack before bedtime. Unsampled Resident #1 stated I guess they would if I asked. When asked if anyone offered her a snack she stated, "No." On 04/13/17 at approximately 7:45 a.m. the surveyor spoke with unsampled Resident #2 and #3 who were roommates. Both of these Residents were asked if they were offered a snack at night. Both of the Residents verbalized to the surveyor that they were not offered a snack at night. Unsampled Resident #3 then stated she didn't ask for one. Unsampled Resident #4 stated he was treated well by the staff and if he asked	F 368		

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F 368	Continued From page 55 for one they would get him one. Unsampled Resident #5 stated No, but I don't want one. Unsampled Resident #6 said if I ask they will give me one. Unsampled Resident #7 said no, but sometimes I wake up and find one on the table. On 4/13/17 approximately 10:30 am, during an interview with the dietary manager she was asked if bed time snacks were offered to the residents she stated we send snacks trays up three times a day. She was asked were these for people with special diets she responded some of them. She also informed the surveyor that she stocked the panty with snacks. Surveyor #1 checked the pantry and found the following: 2 large jars of peanut butter in the cabinet, crackers in the drawer, and ready-made sandwiches in the fridge, thickened liquids, sodas, and ice cream. At 10:40 am the director of nurses was asked if the CNA's offered the residents a bedtime snack. She stated "I cannot say that the CNA's are offering a bed time snack." RN #4 provided the surveyor with a list of Residents she had asked if they received bed time snacks. From the list of resident who could have a snack only 12 said yes, they were offered a snack, 16 said no, they were not offered. Others said they could get a snack if they asked for one. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 368		
F 371	483.60(i)(1)-(3) FOOD PROCURE,	F 371		

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F 371 SS=F	Continued From page 56 STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews , the facility's staff failed to provide a clean and sanitary kitchen environment, and failed to ensure expired nutritional supplements were discarded. The findings include: 1. The initial tour of the kitchen was conducted on 4/11/17 at 11:35am. The dietary manager gave the tour of the kitchen. The ceiling tile in front of the stove/hood was noted to have black debris	F 371	The tiles and black debris was cleaned on 4/11/17. The ice machine drain pipe was fixed on 4/11/7. Expired items in the kitchen and Central Supply room were immediately discarded. Current residents in the center have the potential to be affected. Maintenance Director/Dietary Manager/Central Supply staff was educated by The Chief Administrative Officer(CAO)/Director of Nursing(DON)/designee for maintaining the drain pipe on the ice machine, to report any areas in the kitchen needing repairs or attention and rotating stock in the central supply room and in the kitchen to check for expired items. Facility staff was educated to check for expiration dates prior to using any product with an expiration date. The CAO/DON/designee will monitor the ice machine weekly to ensure the drain pipe on the ice machine has the proper air gap, kitchen inspections will be conducted weekly to ensure no expired items, cleanliness of tiles and the absence of black debris and the central supply y room will be monitored weekly to ensure no outdated supplies. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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F 371	Continued From page 57 covering the center and outward on most of the tile. In the room where the dishwasher was located, there were more black and dirty ceiling tiles; many of these tiles looked to have food splattered on them? The dietary manager stated she would notify the maintenance director of the issue. At 4:35pm the surveyor retumed to the kitchen. The ice machine was observed and did not have a proper air gap. The drain pipe entered into a larger drainage pipe at floor level. This did not allow for an air gap between the ice maker drainage pipe and the main drainage system to prevent the possibility of other drainage and bacteria backing up from the floor drain into the ice maker. The surveyor pointed out the ice machine drainage system to the dietary manager and the maintenance director who came into the kitchen at that time. The surveyor explained to them the potential for a possible backup into the ice machine. The maintenance director verbalized understanding, stating, "I see what you mean." The kitchen was revisited on 04/12/17 at 8:30am. The air gap had been corrected. The ceiling tiles had also been cleaned. During an interview with the maintenance director, he informed the surveyor the tiles had been cleaned with a magic eraser and soap and water. The administrator, assistant administrator, and the DON were made aware of the above issues on 04/12/10 at 5:40pm. No further information was provided by the facility concerning the above findings prior to the exit	F 371		

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F 371	Continued From page 58 conference on 04/13/17 at 9:45pm. 2. The facility staff failed to discard nutritional supplements before the expiration dates in the Central Supply Storage area. The state and federal surveyors went to the Central Supply Storage area downstairs from the nursing unit on 4/13/17 at 11 am. The following was found to be expired in the storage area: Ready To Hang Jevity 1.5 (3 ½) cases with expiration date of 2/1/17, IsoSource 1.5 calorie (1 ½) cases with expiration date of 3/28/17 and IsoSource 1.5 calorie (3 ½) cases with expiration date of 4/12/17 and (10) individual packages of leg bags with expiration date of 10/14. The administrative team was notified of the above documented findings on 4/13/17 at 11:35 am by the surveyor. At 3pm on 4/13/17, licensed practical nurse (LPN) #1 stated to the surveyor, "The things you found to be out of date are checked by me and I try to do it weekly, then the nurses on the floor checks the expiration date when they go to hang the tube feeding or give a resident the nutritional supplement. It was just human error that I missed this." No further information was provided to the surveyor prior to the exit conference on 4/13/17.	F 371		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit	F 431		

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F 431	Continued From page 59 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked,	F 431	Medication labels for resident #6 and #17 were corrected to match the physician orders. The narcotic box in the medication room has been permanently affixed. Expired lab tubes and expired stool transport containers were immediately discarded from the medication room. Expired items in the central supply room were immediately discarded. Resident #10 medication administration records were corrected to match the physician orders for times the medication was to be given. A review of medication orders for current residents in the center was conducted to ensure medication labels; times listed on the medication administration records match the physician orders. Current residents in the center have the potential to be affected. Clinical staff was educated by the Director of Nursing/designee on verifying medication labels match the physician orders as well as the time for administration. In addition, the clinical staff and the central supply staff will be educated on discarding expired medications and supplies. The CAO/DON/designee will monitor weekly the central supply y room to ensure no outdated supplies. The DON/designee will audit 10 residents weekly to ensue the medications labels and times on the medication administration record matches the physician orders. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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F 431	Continued From page 60 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure the correct labeling of medication for 3 of 18 residents (Residents #6, #17, and #10), failed to ensure the narcotic box was firmly affixed, and failed to dispose of expired biologicals. The findings included: 1. The facility staff failed to ensure the correct labeling of a medication for Resident #6. Resident #6 was readmitted to the facility on 12/29/16 with the following diagnoses of, but not limited to anemia, high blood pressure, neurogenic bladder, urinary tract infection, anxiety disorder, depression, respiratory failure, dependence on ventilator assistance, tracheostomy, chronic pain and gastrostomy. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/17, coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #6 was also coded as requiring extensive assistance of 2 or more staff members for dressing and being totally dependent 2 or more staff member forbathing.	F 431		

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F 431	Continued From page 61 During the medication pass and pour observation on 4/11/17 at 4:25 pm, LPN (Licensed Practical Nurse) #2 gave Resident #6 Ferrous Sulfate 325 mg (milligram) 1 tablet by mouth and Hydrocodone 7.5/325 mg 1 tablet by mouth. The surveyor reviewed the labeling of the medication which stated the following: "Ferrous Sulfate 325 mg Take 1 tab by mouth twice daily Hydrocodone 7.5/325 mg Take 1 tab by mouth every 4 hours as needed for pain." The surveyor reviewed the clinical record of Resident #6 on 4/12/17. On the physician order sheet for the month of April, 2017 the following orders were noted: "Norco (Hydrocodone) 7.5/325 mg Give 7.5 mg via (by) peg tube every 4 hours for pain Ferrous Sulfate 325 mg Give 1 tablet via peg tube two times a day for supplementation." The administrative team was notified on 4/12/17 at approximately 5 pm by the surveyor of the above documented findings. The surveyor explained to the administrative team that the physician order did not match the label on the medication from which the nurse had administered the medication from. The director of nurses was asked by the surveyor if these were supposed to match. The director of nursing stated "Yes, they should match." The surveyor asked for a copy of the facility's policy on medication administration. On 4/13/17 at 1:45 pm, the director of nursing provided the surveyor with a copy of the facility's policy titled "4.4 Reordering, Changing, and Discontinuing Orders" which stated the following under section 3.5.3:	F 431		

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F 431	Continued From page 62 " ...Facility should notify the Pharmacy not to send the medication. The facility should attach a "Change in Directions" sticker to the existing quantities of medications until the Pharmacy permanently affixes the label to the medication package container ..." On 4/13/17 at 2 pm, the surveyor went back to the nursing floor on which Resident #6 resided on. The surveyor asked the medication nurse for Resident #6 if the label for the Ferrous Sulfate and Hydrocodone could be reviewed. The medication nurse took out these medications and handed them to the surveyor. A "Change in Directions" sticker was now affixed to the pharmacy label which was noted by the surveyor. No further information was provided to the surveyor prior to the exit conference on 4/13/17. 2. The facility staff failed to ensure the correct labeling of a medication for Resident #17. Resident #17 was added to the survey sample as a supplemental resident due to the observation made by the surveyor on the medication pass and pour observation. The surveyor went with Licensed Practical Nurse (LPN) #3 to Resident #17's room to observe the medication pass and pour observation on 4/12/17 at 8:10 am. During this observation, the surveyor noted the label of the medication that was given to the resident read as follows: "Hydrocodone 7.5/325 mg (milligram) Take 1 tablet by mouth every 8 hours." The surveyor reviewed the clinical record of Resident #17 at 10 am and the following	F 431		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 63 physician's order was noted: "Norco (Hydrocodone) 7.5/325 mg Give 1 tablet two times a day." The administrative team was notified of the above documented findings by the surveyor on 4/13/17 at 11:35 am in the conference room. On 4/13/17 at 1:45 pm, the director of nursing provided the surveyor with a copy of the facility's policy titled "4.4 Reordering, Changing, and Discontinuing Orders" which stated the following under section 3.5.3: " ...Facility should notify the Pharmacy notto send the medication. The facility should attach a "Change in Directions" sticker to the existing quantities of medications until the Pharmacy permanently affixes the label to the medication package container ..." On 4/13/17 at 2 pm, the surveyor went back to the nursing floor on which Resident #17 resided on. The surveyor asked the medication nurse for Resident #17 if the label for the Hydrocodone could be reviewed. The medication nurse took out these medications and handed them to the surveyor. A "Change in Directions" sticker was now affixed to the pharmacy label which was noted by the surveyor. No further information was provided to the surveyor prior to the exit conference on 4/13/17. 3. The facility staff failed to ensure the narcotic box was permanently affixed in the medication room on the nursing unit. On 4/12/17 at 10 am, the state and federal surveyors went into the medication room on the	F 431		

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F 431	Continued From page 64 nursing unit of the facility. At this time it was noted, that the orange tackle box labeled " STAT BOX" was in a locked cabinet. The state surveyor asked the medication nurse what was in the tackle box. The medication nurse stated " We have our emergency supply of STAT medications in the box." The state surveyor asked the medication nurse if this emergency supply would contain any narcotics and the medication nurse stated "yes." On 4/12/17 at approximately 5 pm, the administrative team was notified of the above documented findings by the surveyor. The surveyor requested a copy of the contents of the STAT BOX. The director of nursing stated she would provide the surveyor with this copy. The surveyor received a copy of the contents of the STAT BOX on 4/13/17 at 10 am from the director of nursing. The following was noted to be listed on the copy of medications that were in the STAT BOX: Oxycodone APAP 5/325 (2), Oxycodone APAP 7.5/325 (2), Oxycodone APAP 10/325 (2), Oxycodone 5 mg (3), Morphine 20 mg/ml (milligram per milliliter) 30 ml, Hydrocodone APAP 5/325 (2), Hydrocodone APAP 7.5/325 (2), Hydrocodone APAP 10/325 (2), Lorazapam 0.5 mg (4), Alprazolam 0.5 mg (4), Zolpidem 5 mg (2), Tramadol 50 mg (2), Phenobarbatol 32.4 mg (2), Injectable Morphine 10 mg/ml (2), Injectable Diazepam 10mg/ml (2) and Lorazepam 2mg/ml (special order)." The administrative team was again notified of the above documented findings on 4/13/17 at 11:35 am and 6:15 pm by the surveyor. No further information was provided to the	F 431		

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F 431	Continued From page 65 surveyor prior to the exit conference on 4/13/17. 4. The facility staff failed to ensure biologicals were discarded by the expiration date in the medication room and central supply storage area. On 4/12/17 at 10 am, the state and federal surveyors went into the medication room on the nursing unit of the facility. At that time it was noted, by the surveyors that the following was expired in the medication room on the nursing unit: (9) green top laboratory tubes with expiration date of 3/17 and (19) Para-Pak C&S container stool transport with expiration date of 2/17. The state and federal surveyors went to the Central Supply Storage area downstairs from the nursing unit on 4/13/17 at 11 am. The following was found to be expired in the storage area: Ready To Hang Jevity 1.5 (3 ½) cases with expiration date of 2/1/17, IsoSource 1.5 calorie (1 ½) cases with expiration date of 3/28/17 and IsoSource 1.5 calorie (3 ½) cases with expiration date of 4/12/17 and (10) individual packages of leg bags with expiration date of 10/14. The administrative team was notified of the above documented findings on 4/13/17 at 11:35 am by the surveyor. No further information was provided to the surveyor prior to the exit conference on 4/13/17. 5. For Resident #10, the facility pharmacy scheduled the time of administration of the medication Klonopin on the medication label that resulted in confliction with the Medication Administration Record.	F 431		

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F 431	Continued From page 66 Resident #10's clinical record was reviewed 4/13/17. Resident #10 was admitted to the facility on 4/5/16 and readmitted on 1/1/17 with diagnoses that included, but were not limited to: high blood pressure, pneumonia, insomnia, anxiety, depression, chronic obstructive pulmonary disease, respiratory failure, and tracheostomy status. Resident #10's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/6/17 assessed her cognitive status as 15 out of 15 in Section C for Summary Score. Resident #10 could be understood and could understand. The physician's order read: "Klonopin 1mg 1 in the am and 1 po (by mouth) q hs (every hour sleep), 2 po at mid-day." Review of Resident #10's Medication Administration Record revealed the medication Klonopin 1 mg, give I tablet two times a day for anxiety scheduled at 0800 and 2000. Klonopin 1mg, give 2 tablets by mouth one time a day for anxiety was scheduled by the facility staff at 13:00 hours. The pharmacy label read, "Take 1 tab by mouth every morning. Take 2 tabs by mouth 12pm. Take 1 tab by mouth at bedtime." The label scheduled the medication Klonopin at 12:00pm. This conflicted with the scheduling the facility staff had for 1300 hours. On 4/13/17 at 3:40pm, RN #5 was asked if the Pharmacy scheduled the medications. She said. "No, medication times are scheduled at the facility and the scheduling is integrated with the pharmacy."	F 431		

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F 431	Continued From page 67 At 4:00pm, the director of nurses provided the surveyor with a copy of the original physician's order for the Klonopin. It did not have the 12pm time on it. The director of nurses stated, "The pharmacy scheduled it on the label." On 4/13/17 at 6:40pm during the end of the day meeting, the administration, director of nurses, and the regional nurse were informed of the labeling issue. Prior to exit on 4/13/17 at 9:45pm, no further information was provided to the surveyor related to the aforementioned.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441	Infection Control Log was updated to include a column for the resolution date for the infection. A glucometer was placed in Resident #11 to use as long as this resident remains in isolation. Current residents in the center have the potential to be affected. Licensed Nurses have been educated by the Director of Nursing/designee on isolation protocol and equipment use and cleaning of equipment. The QA nurse was educated on the revised infection control log. The Director of Nursing/designee will monitor isolation rooms and equipment weekly to ensure equipment used in isolation rooms remain in the room or are properly cleaned prior to leaving the room. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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F 441	Continued From page 68 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 69 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure the infection control/line list/tracking form was complete and failed to follow established infection control guidelines in regards to isolation for 1 of 18 Residents, Resident #11. The findings included. 1. The facility failed to complete the infection control/line list/tracking form. This form did not include any outcomes in regards to Resident infections. On 04/11/17, during the entrance conference, the administrator was asked to provide the surveyor with the infection control line list (infection control tracking form). The facility provided the surveyor with their "Infection Log" for December 2016-April 2017. A review of the documents indicated they were incomplete. The documents did not identify if the infection's had been resolved or were ongoing (outcome). LPN (licensed practical nurse) #1 who was designated as the QA (quality assurance) nurse verbalized to the surveyor that they did not document on the form when the infections were resolved. On 04/13/17 at approximately 11:45 a.m. during a	F 441		

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F 441	Continued From page 70 meeting with the administrative staff of the facility. The administrative staff were notified that their infection control log did not include any outcomes. The DON (director of nursing) verbalized to the survey team that if the Resident was not on the log for the next month it meant their infection had resolved. This indicated that if a Resident completed an antibiotic the first of the month and was symptom free they would stay on the infection control log until the first of the next month which would indicate their infection was ongoing. The surveyor asked the DON for a copy of their infection control policy in regards to surveillance and outcomes. This policy read in part "The facility has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment. The infection control program is designed to help prevent development and transmission of disease and infection. Infections are investigated , controlled and prevented through implementation of the infection control program...A record is maintained of incidents and corrective actions related to infections..." Per the CDC (Centers for Disease Control and Prevention) website accessed 04/14/17 https://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html, Tracking and Reporting Antibiotic Use and Outcomes, measurement is critical to identify opportunities for improvement and assess the impact of improvement efforts. For antibiotic stewardship, measurement may involve evaluation of both process and outcome. No further information regarding this issue was	F 441		

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F 441	Continued From page 71 provided to the survey team prior to the exit conference. 2. The facility staff failed to follow infection control guidelines with a glucometer for Resident #11. Resident #11 was admitted to the facility on 5/1/13, and readmitted on 4/7/17, with diagnoses that included, but were not limited to: stroke, kidney disease, diabetes mellitus, heart failure, and urinary tract infection. Resident #11's was a new admission and did not have a current Minimum Data Set (MDS) assessment completed. However, he could be understood and he could understand verbal communication. On 4/11/17 at 4 pm, the state and federal surveyors were in the hallway waiting to perform an observation with the medication nurse when the surveyors observed a nurse dressing out in infection control gown, gloves and mask enter the room to Resident #11. The nurse was observed to take a glucometer into the isolation room, use it on Resident #11 and then took off her gown, gloves and mask and returned to the medication cart with the glucometer that she had used in the isolation room. The nurse laid the glucometer on top of the medication cart, reached into the bottom drawer and pulled out a cleaning wipe and wiped the glucometer off. The nurse wore no gloves while performing thiscleaning. The administrative team was notified of the above findings by the state surveyor on 4/12/17 at approximately 5 pm. The state surveyor requested a copy of the infection control guidelines for taking equipment in and out of	F 441		

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F 441	Continued From page 72 isolation rooms. The surveyor received a copy of the policy titled "Infection Control Measures" from the director of nursing on 4/13/17 at 10 am. The policy stated " ...7. Environmental Cleaning:..Sharing of non-critical equipment (such as electronic thermometers, blood pressure cuffs and intravenous poles) should not be permitted ..." The surveyor asked the director of nursing if the glucometer should had been taken into the isolation room and she stated, "The staff should leave one in the resident's room to be used while he is in isolation." No further information was provided to the surveyor prior to the exit conference on 4/13/17.	F 441		
F 456 SS=D	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to maintain patient care equipment according to the manufacturer instructions and their facility policy. The findings included. The facility was unable to provide the survey	F 456	The hydrocollator in the therapy department was cleaned on 4/13/17. Current residents in the center have the potential to be affected. The Director of Rehab was educated by the Corporate Rehab Director on the center's policy for cleaning the Hydrocollator and the documentation of the cleaning. The Chief Administrative Officer/designee will monitor monthly to ensure the hydrocollator is cleaned per center's policy. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	5/28/17

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F 456	Continued From page 73	F 456		

team with evidence that the hydrocollator was cleaned per the manufactures instructions and per their facility policy.

A hydrocollator is a stationary or mobile stainless-steel thermostatically controlled liquid heating device designed to heat packs in water. The packs will be removed and wrapped in several layers of toweling and applied to the affected body area of a patient to relieve acute pain or relax certain muscle groups.

On 04/12/17 the surveyor observed the hydrocollator in the therapy department. After reviewing the temperature logs the surveyor asked about the cleaning schedule. Rehab employee #1 was unable to provide the survey team with any documentation to indicate the hydrocollator had been cleaned and verbalized to the survey team that they did not document anywhere when the unit was cleaned.

On 04/12/17 at approximately 4:50 p.m., during a meeting with the survey team, the administrative staff was notified that the rehab department was unable to provide evidence that the hydrocollator unit had been cleaned.

On 04/13/17 at approximately 10:40 a.m. the corporate director of MDS (minimum data set) provided the surveyor with a copy of their hydrocollator policy. This policy read in part "...Hydrocolator will be cleaned bi-weekly and logged on hydrocolator log maintained in therapy department..." (sic)

The maintenance director identified the brand of the hydrocollator as being a chattanooga. Per the manufactures instructions the unit should be

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F 456	Continued From page 74 cleaned regularly for optimal service and operation and the interior of the unit should be cleaned, at least every two weeks. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 456		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 514	No action taken for resident #2 due to the time frame had passed. No action taken for resident #8 due to the time frame had passed. LPN #1 was educated on the type of diet Resident #4 was receiving and the documentation was corrected in the medical record. No action taken for Resident #4 and the behavior monitoring forms due to time frame had passed. No action taken for resident #12 due to the time frame had already passed. Current residents in the center have the potential to be affected. Licensed nurses were educated by the Director of Nursing/designee on the center's policy for completion of the dialysis form when resident returns to the center. In addition, education included prior to giving pain medications, there must be evidence of non pharmacological interventions attempt prior to the administration of pain medications. These non pharmacological interventions must be documented in the medial record. Licensed Nurses were also educated to ensure their documentation in the medical record is complete and accurate including documentation on the PRN MAR when administrating PRN pain medications. The Director of Nursing/designee will monitor the dialysis communication forms weekly to ensure they are complete. In addition, the Director of Nursing/designee will monitor 5 records weekly to ensure non pharmacological interventions are documented in the medical record. The Director of Nursing/designee will monitor nurses' notes for five residents weekly to ensure the information documented is accurate. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the	5/28/17

			QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 514	Continued From page 75 (v) Physician's, nurse's, and otherlicensed professional's progress notes;and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 4 of 18 Residents (Residents #2, #8, #4, and #12). The findings include: 1. For Resident #2, the facility staff failed to provide documented evidence of non-pharmacological interventions for pain and failed to ensure coding was correct on the Medication Administration Record for Resident #2. Resident #2's clinical record was reviewed on 4/12/17. Resident #2 was admitted to the facility 3/30/16 and readmitted 1/14/16 with diagnoses that included, but were not limited to heart failure, chronic obstructive pulmonary disease, respiratory failure, urinary retention, diabetes mellitus, atrial fibrillation, and hypothyroidism. Resident #2's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/17/17 assessed the cognitive status as 15 out of 15 in Section C Summary Score. Resident #2 required extensive assistance of 2 people for transfers and toileting. Resident #2 was coded in section J to have pain, with an intensity rating from 00-10, her rating was an 8. The current comprehensive care plan initiated	F 514		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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3/31/17, read in part: "Risk for pain/discomfort due to chronic physical illness, diabetic neuropathy." Interventions: "Offer change in position, assist as needed." There were no other interventions listed.

Review of the Resident's current physician's summary of orders dated 4/3/17 revealed Resident #2 had an order for Percocet tablet 10-325 mg given every 6 hours as needed for pain (PRN). The start date for the Percocet was 1/14/17.

Resident #2's PRN medication documentation sheet revealed she received pain medication on 3/5/17 at 12:10pm, on 3/7/16 at 10:00pm, and on 3/8/17 at 1:00pm, for general complaint of pain. There was documentation of the results to indicate the medication was effective. There was no documentation in the nurse's progress notes or the MAR to indicate if non-pharmacological interventions had been tried prior to the administration of the medication.

Resident #2's PRN medication documentation sheet revealed she received pain medication on 3/11/17 at 12:00, again on 3/12/17 at 12:00, and on 3/13/17 at 12:15, for general complaint of pain. There was documentation of the results to indicate the medication was effective. There was no documentation in the nurse's progress notes or the MAR to indicate if non-pharmacological interventions had been tried prior to the administration of the medication.

Resident #2's PRN medication documentation sheet revealed she received pain medication on 3/15/17 at 12:10pm, on 3/16/17 at 6:00pm, for shoulder pain, and on 3/17/17 at 12:30, for

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general complaint of pain. There was documentation of the results to indicate the medication was effective. There was no documentation in the nurse's progress notes or the MAR to indicate if non-pharmacological interventions had been tried prior to the administration of the medication.

Review of the pain medication documentation form revealed the form had a place for the date, time, nurse's initials, drug-dose, site of administration, reason to give the medication, and the results. Also, there was a chart code area listing a numbered reason for the administration of the medication. The form had a place for the nurse's signature. There were no nurse's signatures listed on the form. The date, time, and the nurse's initials were documented. The name of the drug Percocet for the dates listed above was documented, however, there was no dose documented on the form. The site listed was PO (by mouth), the reason for giving the medication was documented. Beside the name of the medication were numbers listed, these numbers did not correspond with the chart of codes.

On 4/13/17 at 7:55pm, the director of nurses was asked what the numbers written beside the medications were. She said, "The level of pain." The surveyor then pointed out that the chart of codes did not contain a number for the level of pain. She looked and said, "I see."

The surveyor informed the administrative staff of the above finding on 4/12/17 at 5:40pm and again on 4/13/16 at 6:40pm. The Regional nurse consultant verbalized to the survey team that non-pharmacological interventions were attempted but may not have been documented.

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F 514	Continued From page 79 On 4/13/17 at approximately 1:45 pm, the surveyor received a copy of the contract with the dialysis center that stated," ...Both parties shall ensure that there is documented evidence of collaboration of care with communication between the Nursing Facility and ESRD Dialysis Unit ..." No further information was provided to the surveyor prior to the exit conference on 4/13/17. 3. For Resident #4, the facility staff inaccurately charted in the Residents clinical record that the Resident was on a mechanical soft diet when in fact the Resident was receiving a purred diet and failed to consistently complete the Residents behavior monitoring sheets. The record review revealed that Resident #4 had been admitted to the facility 04/03/13. Diagnoses included, but were not limited to, diabetes, major depressive disorder, dementia, peripheral vascular disease, anorexia, and hypertension. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/13/17 was coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. Section G (functional status) was coded 4/2 for eating to indicate the Resident was totally dependent on 1 staff. Section K (swallowing/nutritional status) was coded to indicate the Resident was on a mechanically altered diet. a) The Residents clinical record included an order	F 514		

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F 514	Continued From page 78 Prior to exit, no further information was provided to the surveyor. 2. The facility staff failed to maintain a complete and accurate clinical record for Resident #8. Resident #8 was admitted to the facility on 2/8/17 with the following diagnoses of, but not limited to anemia, Coronary Artery Disease, heart failure, high blood pressure, End-Stage Renal Disease, Pneumonia, Diabetes, high potassium, high cholesterol, depression and respiratory failure. The MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/17 scored the resident as having a BIMS (Brief Mental Status) score of 14 out of a possible score of 15. Resident #8 was also coded as requiring extensive assistance of 2 staff members for personal hygiene and dressing. The resident was coded as being totally dependent on 2 or more staff members for bathing. During the clinical record review on 4/11/17 and 4/12/17, the surveyor noted that there was missing documentation on the dialysis communication sheets titled "Dialysis Communication and Follow Up Record" for the following dates which would include the pre and post dialysis weights of Resident #8: 2/27/17, 3/10/17, 3/15/17, 3/20/17, 3/22/17, 3/27/17 and 4/10/17. The administrative team was notified of the above findings by the surveyor on 4/12/17 at approximately 5 pm. The director of nursing stated "that section is to be completed by the dialysis center prior to the resident returning to the facility." The surveyor asked for a copy of the dialysis contract.	F 514		

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F 514	Continued From page 80 summary sheet that identified the Resident as receiving a RCS (reduced concentrated sweets) puree texture diet. The order date and start date were both documented as 01/09/17. This order summary sheet had been signed by the attending physician on 04/03/17. The Residents diet ticket read "Texture pureed." The Residents clinical record included the following documentation for 02/17, 03/10, 03/31, and 04/07 "...Resident is on a RCS mechanical soft diet..." All of these entries had been documented by LPN (licensed practical nurse) #1. On 04/11/17 at approximately 4:10 p.m. the surveyor interviewed CNA (certified nursing assistant) #1 who identified the Resident as receiving a purred diet. The surveyor observed the breakfast tray on 04/12/17 and it was observed to be of a purred consistency. b) Resident #4 was receiving the following medications clonazepam 0.25 mg, sertraline (zoloft) 150 mg, and ziprasidone (geodon) 20 mg. The clinical record included behavior monitoring sheets for each of the above named medications. For the medication clonazepam the staff were monitoring for anxiety. For sertraline the staff were monitoring the behaviors of crying, hitting, and kicking and for ziprasidone the staff were monitoring the behaviors of yelling, hitting and kicking. On 04/01, 04/02, 04/06, 04/07, and 04/10/17 the evening shift staff had left the behavior monitoring sheets blank for all of the	F 514		

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F 514	Continued From page 81 medications. The administrative staff was notified of the inaccurate documentation regarding the Residents diet and the incomplete documentation regarding the Residents behavior monitoring sheets on 04/13/17 at approximately 11:45 a.m. during a meeting with the survey team. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #12, the facility staff failed to consistently document the Resident's assessment upon his return from dialysis. The record review revealed that Resident #12 was admitted to the facility 03/15/16. Diagnoses included, but were not limited to, end stage renal disease, acute respiratory failure, polycystic kidney disease, essential hypertension and major depressive disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/06/17 included a BIMS (brief interview for mental status) summary score of 15 of 15 points. Section O (special treatments/procedures/programs) was checked to indicate the Resident was receiving dialysis. The Resident's comprehensive care plan included the focus area of hemodialysis/end stage renal disease and included the interventions monitor shunt for presence of bruit & thrill, redness, warmth or swelling at site and monitor and record weights and VS (vital signs)	F 514		

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F 514	Continued From page 82 per physician orders. The Resident's physician signed (04/03/17) order summary report included an order for dialysis on Monday-Wednesday-Friday and weights per protocol. On 04/13/17 at 1:35 p.m. the DON (director of nursing) provided the survey team with a copy of their policy/procedure regarding dialysis patients. This policy/procedure read in part "Assessment & Documentation-Residents will be assessed pre and post dialysis...Document...The resident's condition, vital signs and response to dialysis treatment should be documented..." The facility staff kept a dialysis folder for each dialysis patient that included labs and a communication form and follow up record. This communication form included a section A, a section B "TO BE COMPLETED AT DIALYSIS CENTER PRIOR TO DISCHARGE", and section C. Section C was "TO BE COMPLETED BY LTC (long term care) FACILITY UPON RETURN" and included areas for VS (vital signs), notable changes, new orders, lung sounds, and the nurses signature. On the forms dated 04/12, 04/10, 04/07, and 04/05 section C had been left blank. On 04/13/17 at approximately 3:40 p.m. the surveyor spoke with Resident #12 in his room. Resident #12 verbalized to the surveyor that the facility staff obtained his VS and assessed him when he retumed to the facility. The VS that had been documented under the VS tab in the clinical record for the days of 04/12, 04/10, 04/07, and 04/05 matched exactly with the	F 514		

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F 514	Continued From page 83 VS documented on section B of the dialysis communication form. Which was the section completed at the dialysis center. The administrative staff were notified of the inconsistent documentation regarding Resident #12 during a meeting with the survey team on 04/13/17 at approximately 6:35 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 514		